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10/12/15

Attn: Candis Jones Re Caverna Watson vs 1180 Peachtree Office Investors

This letter is written to provide a report of the opinions that I may offer with regard to left shoulder pain Ms. Caverna Watson alleges to have sustained in a slip and fall in a parking lot at work, on 5/4/2012.

I have had a chance to review the surveillance video. I have reviewed the pertinent medical records provided relating to Ms. Caverna Watson. Based on my education, training, professional experience, and review of the materials provided, if called to be a witness in your case, I will testify to a reasonable degree of medical probability to the following:

Summary of Opinions:
I am a licensed and Board Certified orthopedic surgeon practicing medicine in metro Atlanta.

I was asked by attorney Candis Jones to review the medical file of Ms. Caverna Watson to provide my medical opinions relevant to the reported slip-and-fall accident. I agreed to do so and charged a customary and reasonable fee for this review, at the rates outlined on the Fee Schedule submitted with this Report.

I reviewed Ms. Watson's pre-and post-accident medical records and radiographic/diagnostic films to the extent provided. The following are my medical opinions, given to a reasonable degree of medical probability if not certainty, along with the basis and reasons for them.

It is my medical opinion within a reasonable degree of medical certainty that Ms. Watson did not sustain objective left shoulder pathology beyond a strain, as a result of the slip and fall.

It is also my medical opinion that the findings on Ms. Watson's MRI, beyond a strain, were not caused by the incident slip and fall and are consistent with her age and co-morbidities.

It is further my medical opinion that the post-surgical complications she developed are not related to the incident slip and fall.

Pre-existing Morbidities:
At the time of her fall, she was an obese 54 y/o female with high BMI of 40.5 at 5'5, 250 lbs. She was employed as a cook with Highland Bakery. She was divorced. She had been smoking since the age of 25, and drank occasionally. She was s/p total hysterectomy, intestinal repair, and tonsillectomy. S/p previous workers comp injury of a burn to her fingers in September 2010. She had allergies to ASPIRIN, PENICILLIN, and CODEINE (though drug tests came back positive for Codeine).

The mechanism of injury:
She was on a break at work and was walking to the smoking area with her breakfast when she fell. Security was alerted and responded to find her sitting on the ground requesting assistance to stand up. She related she had fallen on her RIGHT knee and it was hurting. She was escorted

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home via cab and instructed to go to the Emergency Room to have x-rays taken of her knee and shoulder, which she did the next day. In the surveillance video, she does break her fall with her hands and her left arm moreso than her right. It does appear that she could have strained her left shoulder. That said, during the entire time she is sitting on the ground, she is leaning on her extended left arm as a support. That would suggest that her left shoulder is not acutely injured of significance at that moment.

Care:

On 5/5/2012, one day following her fall she presented to DeKalb Medical Center for evaluation for bilateral knee pain and bilateral shoulder pain; but primarily her left shoulder pain. On physical examination her skin showed no lacerations or abrasions. Examination of her left shoulder showed pain over the musculature of the rotator cuff, and decreased ROM. Forward and lateral extension were limited to 90 degrees and she was unable to get her arm all the way over her head though she had good strength in the shoulder. X-rays were taken of her knees, left shoulder, and right hip and were all mostly unremarkable. The left shoulder films were available for my review and showed mild degenerative and chronic changes at the AC joint. She was discharged to follow up with her PCP.

She had subsequent care at Grady Hospital and with PCP Dr. Ahmad Jingo. She subsequently treated with Jose Alvarez, DC of Atlanta Health Unlimited. She related she was having severe left shoulder pain, low back pain, right hip pain, and right knee pain. Beyond chiropractic care, an MRI of her left shoulder was ordered.

Imaging studies:

Imaging studies have been provided for our review, including x-rays of her hip, bilateral knees, chest, and left shoulder from multiple dates, which are duplicate studies from what were previously provided for this review. An additional disc with her MRI from 6/28/2012 is reviewed. It is a low-resolution study of questionable technique.

On 6/8/2012, one month after her fall, an MRI of her left shoulder without contrast was taken with findings that included:

1. No evidence of a complete rotator cuff tendon tear, but significant deformity of the supraspinatus tendon, most compatible with strain, though possible partial tear.
2. Mild degeneration of the AC joint with minor inferior prominence.
3. The radiologist could not exclude deformity of the superior labrum but this was indefinite and correlation was necessary.

I do not see any deformity of the supraspinatus tendon. I would agree about the mild and moderate degenerative findings as described in the report.

These findings on MRI are non-specific for acute trauma. They are common for her age and likely represent degenerative processes. The rotator cuff did not show any signs of tearing on this non-contrast study. The supraspinatus tendon findings were non-specific but suggestive of a strain. The other findings on this MRI are either chronic or age-indeterminate.
Notably absent are any clear signs of acute trauma: hemorrhage, bleeding, soft tissue swelling, bone contusions, contra coups edema patterns, post-traumatic effusion, bursitis, synovitis or occult fracture. Such injuries, were they present, should still have been present on MRI one month after injury.

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She subsequently treated with Dr. Thomas Branch. At the first visit, surgery was recommended. It does not appear that she had undergone any injection therapy in her shoulder. The extent of pre-operative physical therapy directed toward her left shoulder is unclear from the records, but it appears to be minimal. It appears she had chiropractic type of manual therapy but not proper orthopedic Physical Therapy.

I have no opinion on the surgery (as I don't have the arthroscopic pictures to show redness) other than to say that it seems to have been performed without the patient having undergone the standard non-surgical care first. On 8/1/2012, three months following her injury, she underwent LEFT SHOULDER surgery performed by Dr. Branch. Procedures included:

1. arthroscopy, labral repair
2. capsulorrhaphy
3. distal clavicle resection
4. subacromial decompression

The AC joint was narrowed with evidence suggesting compressive injury to the distal clavicle noted during resection.

Post operative diagnoses included:

1. Shoulder dislocation
2. Shoulder labral detachment
3. Arthritis; shoulder
4. Biceps long head tenosynovitis
5. Subacromial bursitis

The MRI, per report, did not show any of these reported findings, nor did it show the physiologic effects of them, as would be expected had they been related to the incident fall. It is unlikely that the patient would have needed procedure #3, distal clavicle resection, especially based upon the absence of any objective injury to this area. Had it been injured, it is often treated successfully without surgery, especially with a properly placed injection. The other procedures may have been indicated, but I cannot directly relate the need for them to a specific fall or traumatic slip. A slip and fall of the nature described, is not a mechanism likely to cause the pathology reported at surgery, but not seen on her MRI, which was likely normal for her age and co-morbidities.

On 12/20/2012, approximately 4.5 months after her first surgery, there is an office note from Dr. Branch which states that the previously resected AC joint is narrow on x-ray. I reviewed the left shoulder x-rays from 3 weeks prior on 11/29/2012, which demonstrated no narrowing of the AC joint. It would be virtually impossible for a properly resected distal clavicle to have regrown pathologically in such a short period of time.

On 2/11/2013, nine months s/p injury and six and a half months s/p surgery, a repeat left shoulder non-contrast MRI was performed of the left shoulder. Findings included:

1. Supraspinatus tendinopathy with high grade partial undersurface tear of the supraspinatus. Small focal areas of increased T2 signal along the peripheral undersurface fibers (rim-rent tears).
2. AC joint degenerative changes
3. Subacromial-subdeltoid bursitis

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4. Postop changes within the labrum with abnormal configuration and signal within the superior labrum, posterior labrum, and anterior labrum. Unclear if they are postoperative changes or related to residual, new or recurrent labral tears.

These MRI findings are not unexpected given the prior surgical history. They do not suggest a problem necessitating surgery.

On 10/2/2013, one and a half years s/p her fall, and one year and two months s/p her index procedure, a second surgery was performed by Dr. Branch.
Procedures included:

1. Arthroscopy, long head of the biceps release
2. Distal clavicle resection (though it had previously been resected)

Despite the MRI findings suggesting a high grade tear of the supraspinatus, no tearing was seen at arthroscopy.

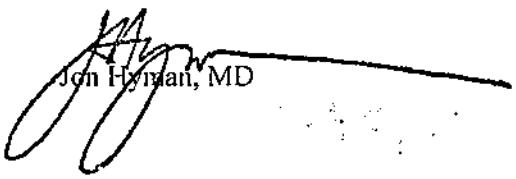
The patient apparently developed two complications from her surgeries:

1. arthrofibrosis and/or adhesive capsulitis
2. heterotopic bone formation

It does not appear that she had pharmacologic or radiologic prophylaxis to prevent these complications. There may have been a component of compliance with proper physical therapy, or access to such therapy which could have influenced these complications. The necessity of the surgeries has not been established.

These opinions are based upon a reasonable degree of medical certainty.

Respectfully,



Jon Hyman, MD